Lourdes Health Network

POLICY/PROCEDURE

FACILITY: **LHN**
DEPT NO: **01.8530**
POLICY NO: **8530-250**
DEPARTMENT: **Business Services**
TITLE: **Charity**

STANDARD: Handle application of charity to all patients equally.

POLICY: It is the policy of LHN to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within LHN

PROCEDURE:

DEFINITIONS
For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an LHN and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined LHN and herein based on a substantive assessment of their ability to pay ("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify charity based on this policy.

PRINCIPLES

All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

1. This policy applies to all services provided in the inpatient or outpatient acute care setting, including behavioral health.

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2. Our facility must ensure that:
    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
    b. Patients receive prompt access to charge information for any item or service provided.
    c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
    d. Financial counselors are available to all Patients.
    e. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
    f. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.
    g. All patients who do not qualify for charity care are offered appropriate extended payment plans.
    h. All outstanding balances on accounts are pursued fairly and consistently, in a manner that reflects Lourdes Health Network values and mission.

3. Charity Care (Minimum Standards) and Financial assistance
    a. At a minimum, Patients with income less than or equal to 200% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services.
    b. At a minimum, Patients with incomes above 200% of the FPL but not exceeding 300% of the FPL.
    c. Eligibility for charity care may be determined at any point in the revenue cycle.
    d. Eligibility for charity care must be determined for any balances for which the patient is responsible.
    e. Charity can also be approved when it exceeds FPL in the case of catastrophic medical expense using the means test.
    f. Charity applications are analyzed and letter of the decision notifies the patient.
    g. National wage index will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
    h. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income. The Means Test will be determined by

each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.

i. Lourdes Health Network has a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.

4. Uninsured Patients with the Ability to Pay
    a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
    b. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
    c. A prompt pay discount must be provided to all of these Uninsured Patients.

5. Collection Practices
    a. Liens on personal residences are permitted only in the following circumstances:

        i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
        ii. The lien will not result in a foreclosure on a personal residence.
        iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
    b. Garnishments of wages are permitted only if:
        i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, and a court determines that the Patient's wages are sufficient for garnishment.
        ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
    c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
    d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
    e. Interest charges on outstanding balances may only be assessed if:
        i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements and,

ii. No add-on to minimum discount is applied in accordance with Section 5b.

f. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

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Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
    a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
    b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

Lourdes Health Network

POLICY/PROCEDURE

FACILITY: **LHN**
DEPT NO: **01.8530**
POLICY NO: **8530-373**
DEPARTMENT: **Business Services**
TITLE: **Process for Financial Assistance Application**

STANDARD:

POLICY: Review Process for Financial Assistance Applications

PROCEDURE: Steps taken in processing Lourdes Health Networks Financial Assistance applications

I. When a Financial Assistance application is received:
   1. The application must be received with all the required information or justification as to why the required information is not received.
      a. Verification of income: copies of current 1040 tax forms and current pay stubs, children's birth certificates if no 1040 available. If the account is from an old date of service we will also need the income from the year the account was incurred.
      b. Application must be completed.
      c. Determination letter from DSHS if the patient is: over the age of 65, disabled, under the age of 19, or pregnant.
   2. If the application is received with out any of the prior requirements the application is denied and the patient is sent out a Denial Letter explaining why the application was denied.
   3. If the patient then responds to the Denial Letter by supplying the required information the review process is started.

II. Review process:
   1. The application is reviewed page by page by the Supervisor.
   2. The percentage of the discount approval is determined by the Federal Poverty Guidelines for household income employing a graduated scale from 200% to 300%. The discount is applied in % increments. Current 2008 Federal Poverty Guidelines are as follows:

Size of family	Poverty Guideline 2008
1	$10,400
2	$14,000
3	$17,600
4	$21,200
5	$24,800
6	$28,400
7	$32,000
8	$35,600

For family units with more then 8 members, add $3,480.00 for each additional member.

Original Effective Date: 01/18/2005
Original Dept: Business Services Supercedes: 600B

Date of Revisions:02/05, 03/05, 01/06,07/06,09/06,01/07,06/07 ,01/08, 05/08, 10/08
Date of Reviews:6/05,02/06;04/07,03/08,06/09
Date of Archive: Superceded by:

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3. If the household income falls between 0%-199% they will receive a 100% discount, between 200%-219% they will receive a 90% discount, between 220%-239% they will receive a 80% discount, between 240%-259% they will receive a 70% discount, between 260%-279% they will receive 60% discount, between 280%-299% they will receive 50% discount.
4. If the patient is over 300% of the Federal Poverty Guidelines they are sent a denial letter and may appeal at any time.
5. In the circumstance that a patient is temporarily unemployed the discount will be based on the annualized income.
6. After the percentage of discount is determined the Supervisor will print out a Financial Assistance Table. This Table will attach the explanation of the determination to the application.
7. On accounts that the patient is on an open welfare coupon but the account is not paid and deemed uncollectable the account may be written off to charity care.

III. Approval
1. Any discounts under the amount of $1000.00 are reviewed and approved by the Credit and Collection Supervisor.
2. Any discounts from $1001.00 to 2500.00 are reviewed and approved by the Director of Business Services.
3. The Director of Business Services and the Chief Financial Officer on a biweekly basis must approve any discounts over $2501.00.

IV. Determination notification to the patient for Lourdes Medical Center Accounts and Lourdes Counseling Center accounts that are Final Bill.
1. The Supervisor using the contractual adjustment code takes the appropriate % of discount.
2. If the discount is not 100% a payment arrangement is put in place if it does not already exist.
4. Application is the finalized by the following steps:
    a. Notate the % of discount on to the patients account.
    b. Send an acceptance letter to the patient.
    c. Update any outside agencies of discount.
    d. File in the Daily File.

V. Determination notification to the patient for Lourdes Counseling Center Account that are Interim Bill.
1. The application is forwarded to the appropriate biller.
2. The biller will add the discount amount onto the account using the insurance mnemonic ADISC%.
3. The biller will send out a Financial Assistance Update Letter every six months. This letter will ask the patient for a current copy of income and any other financial changes.
4. When this information is received the application will go back to the beginning of the review process listed above.
5. If the requested information is not received the ADISC% is taken off any current bills and the patient will be billed for 100% of any self-pay balances.
6. The application is then filed in the biller daily file with a notation on the account in meditech.

VI. Appeal Process
1. If the patient does not agree with Lourdes Health Network they may appeal the decision.

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a. Lourdes Health Network will apply their application to the Lourdes Health Network Means Test.
b. The appeal cover letter will be printed and filled out by the department documenting the rationale for the original discount percentage.
c. This cover letter will be attached to the original Financial Assistance application and forwarded to the Appeal Committee for review.
d. Patient will be advised for discount approved or denied by letter.